5431 MARYLAND STATE DEPARTMENT OF HEALTH 05405

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
LENGTH OF STAY (in this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) GORDON - B - ARMACOST
4. DATE OF DEATH (Month) (Day) (Year) June 26 1954

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Sept 24-1903
9. AGE last birthday 50 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY Body Building
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Emerson R. Armacost
14. MOTHER'S MAIDEN NAME Maggie M Ebaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY No. 218-01-4542
17. INFORMANT AND ADDRESS Elmer Stiffler, Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1

Immediate cause (a) Coronary Thrombosis — Motor

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE M. C. Porterfield (Degree or title) M.D. ADDRESS Hampstead, Md DATE SIGNED 6-26-54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF June 29/54
NAME OF CEMETERY OR CREMATORY Hampstead
LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REG. 6/28/54
REGISTRAR'S SIGNATURE Henry J Kens
24. FUNERAL DIRECTOR Edw C Tipton, Hampstead Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUN 30 1954
BUREAU V. S.

MARYLAND 5432

05406

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 11yrs.7mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg 01-22-2
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Daniel (Middle) James (Last) Bahen
4. DATE OF DEATH (Month) June (Day) 25 (Year) 1954
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 3-8-21
9. AGE last birthday 33 yrs. If under 1 year: Months. Days. If under 24 hrs: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Bahen
14. MOTHER'S MAIDEN NAME Anne Nolan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. Unk -
17. INFORMANT AND ADDRESS Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X

Immediate cause (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 24 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, catatonic type. — 11½ yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to June 25, 1954, that I last saw the deceased alive on June 25, 1954, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt (Degree or title) M.D. ADDRESS Springfield State Hospital DATE SIGNED 6/25/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 6-28-54 NAME OF CEMETERY OR CREMATORY Frostburg LOCATION (City, town, or county) Frostburg, Md (State)

DATE REC'D BY LOCAL REG. June 26, 1954 REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Jacob Hafer - Frostburg, Md. ADDRESS

MARGIN RESERVED FOR BINDING

M

I

RECEIVED
JUN 28 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5433 CERTIFICATE OF DEATH

Reg. Dist. No. 80 05497

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN New Windsor
LENGTH OF STAY (in this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS High Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
STREET ADDRESS (If rural give location) High Street

3. NAME OF DECEASED: (Type or Print) (First) ROSANNA (Middle) E (Last) BURGESS

4. DATE OF DEATH: (Month) June (Day) 13 (Year) 19 54

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: July 5-1864

9. AGE last birthday: 89 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Otey J Reed

14. MOTHER'S MAIDEN NAME: Mary Ann Foster

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mrs Samuel Rabes, New Windsor Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Cardio-Vascular Disease — Interval Between Onset And Death: 10 Yrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1/50, 19..., to 6/13/54, 19..., that I last saw the deceased alive on June 12, 1954, and that death occurred at 3:15 A, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
M E Robertson M.D. New Windsor, Md. 6/13/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF June 15-1954
NAME OF CEMETERY OR CREMATORY Burgess Cemetery
LOCATION (City, town, or county) (State) Floyd Co. Virginia

DATE REC'D BY LOCAL REGISTRAR June 14/54
REGISTRAR'S SIGNATURE Grace L Burdette

24. FUNERAL DIRECTOR D D Hartzler & Sons ADDRESS New Windsor Md

RECEIVED
JUN 15 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

5434 2411 N. Charles Street, Baltimore 05408

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 110 S Main St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural, give location) 110 S Main St

3. NAME OF DECEASED (Type or Print) (First) Eli (Middle) W. (Last) Burgoon
4. DATE OF DEATH (Month) 6 (Day) 30 (Year) 1954

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 2-12-69
9. AGE last birthday 85 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret Teacher
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) Carroll co md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John W Burgoon
14. MOTHER'S MAIDEN NAME Mandilla Sneak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT AND ADDRESS Trivia Wink, Manchester, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arterio Sclerotic C-V-Disease — INTERVAL BETWEEN ONSET AND DEATH 2 wks

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-16, 1954, to 6-30, 1954, that I last saw the deceased alive on 6-30, 1954, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE M Parterfield, M.D (Degree or title) ADDRESS Hampstead, Md DATE SIGNED 6/30/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7-3-54
NAME OF CEMETERY OR CREMATORY Manchester Cem.
LOCATION (City, town, or county) Manchester Carroll co md (State)

DATE REC'D BY LOCAL REG. July 1-54
REGISTRAR'S SIGNATURE Mrs. W. S. Denver
24. FUNERAL DIRECTOR A B Wink Manchester Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 2 1954
BUREAU V. S.

5428 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05409

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; LENGTH OF STAY (in this place) 20 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 27 Milton Avenue	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; STREET ADDRESS (If rural, give location) 27 Milton Avenue

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Thomas	Ephriam	Burgoon	June	6	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married	Apr. 9, 1870	84 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Carpenter	Gen. Cons.	Union Mills, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Aaron Burgoon	Louise Hornberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	219-05-6426	Mrs. Flora Burgoon Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.1 **Immediate cause**	(a) ACUTE PULMONARY EDEMA	5 MIN
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) MYOCARDIAL INFARCTION	10 MIN
	(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	14 YRS
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	BENIGN PROSTATIC HYPERTROPHY	5 YRS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3/29/54	BENIGN PROSTATIC HYPERTROPHY	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5/12, 1954, to 6/6, 1954, that I last saw the deceased alive on 5/29, 1954, and that death occurred at 11:02 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William L. Stewart, M.D.		WESTMINSTER, MD.	6/7/54

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 9, 1954	Hillside Cemetery	Roslyn, Montg. Co. Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6/9/54	Harriet H. Faulkner	John R. Byers	Westminster, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 9 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05410

5435 CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linwood
LENGTH OF STAY (in this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linwood Rural
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) J (Middle) HARRY (Last) BUTLER
4. DATE OF DEATH: (Month) June (Day) 10 (Year) 1954
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: 10/28/1880
9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: own farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Samuel Butler
14. MOTHER'S MAIDEN NAME: Ann Haines
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Goldie Tyneson, Linwood, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset And Death
Immediate cause	(a)	Coronary Occlusion	6-10-54
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b)	Probably Intestinal obstruction	6-9-54 6 P.M
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-9-, 1954 to 6-10-, 1954, that I last saw the deceased alive on 6-10, 1954, and that death occurred at 6:30 A.M. from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
[signature] M.D. Union Mills 6-10-54

23. BURIAL, CREMATION, REMOVAL (Specify) burial
DATE THEREOF 6/12/54
NAME OF CEMETERY OR CREMATORY Linganore Cem.
LOCATION (City, town, or county) (State) Unionville, Md
DATE REC'D BY LOCAL REGISTRAR June 10, 1954
REGISTRAR'S SIGNATURE Leslie L. Repp
24. FUNERAL DIRECTOR D. D. Hartzler & Sons ADDRESS New Windsor, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5436 **CERTIFICATE OF DEATH** Reg. Dist. No. 05411

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Uniontown Rural
LENGTH OF STAY (in this place) 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cookson Boarding Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Uniontown
STREET ADDRESS (If rural give location) Main St

3. NAME OF DECEASED: (Type or Print) (First) FLORENCE (Middle) E (Last) COOKSON
4. DATE OF DEATH: (Month) June (Day) 11 (Year) 1954

5. SEX: f
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: Oct 1869
9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Carroll Co, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hiram Englar
14. MOTHER'S MAIDEN NAME: Elizabeth Engel

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Edwin Engel, Union Bridge Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 5 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic C-V disease — years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 4, 1954, to June 11, 1954, that I last saw the deceased alive on June 10, 1954, and that death occurred at 12:05 P.M., from the causes and on the date stated above.

SIGNATURE James T. Marsh (Degree or title) M.D. ADDRESS Westminster Md DATE SIGNED 6/11/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 6/13/54
NAME OF CEMETERY OR CREMATORY Methodist
LOCATION (City, town, or county) Uniontown (State) Md

DATE REC'D BY LOCAL REGISTRAR June 12, 1954
REGISTRAR'S SIGNATURE Margaret R. Englar
24. FUNERAL DIRECTOR D D Hartzler & Sons, New Windsor, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 15 ...
BUREAU V. S.

MARYLAND 5437 05412

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 2-12

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Nr. Silver Run, Md.
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mailing Address Littlestown, Pa. R.D.1

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Nr. Silver Run, Md.
STREET ADDRESS (If rural, give location) Mailing Address Littlestown, Pa. R.D.1

3. NAME OF DECEASED (Type or Print) (First) Edward (Middle) Wilson (Last) Crouse

4. DATE OF DEATH (Month) 6/22/54 (Day) (Year) 19

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH 8/21/1883

9. AGE last birthday 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Own Farm

11. BIRTHPLACE (State or foreign country) Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David Crouse

14. MOTHER'S MAIDEN NAME Sarah Stair

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Mrs. Katie C. Crouse Littlestown, Pa. R.D.1 (Mrs Katie C. Crouse)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) GENERALIZED ARTERIOSCLEROSIS — Interval between onset and death: 9 YRS

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JUNE 11, 1954, to JUNE 22, 1954, that I last saw the deceased alive on JUNE 22, 1954, and that death occurred at 9:50 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) MD ADDRESS Littlestown Pa DATE SIGNED 6/23/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 6/25/54 | NAME OF CEMETERY OR CREMATORY St. Marys Union Cemetery | LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.

DATE REC'D BY LOCAL REG. 6/24/54 | REGISTRAR'S SIGNATURE Barnett Miller, asst | 24. FUNERAL DIRECTOR ADDRESS J. M. Little & Son Littlestown, Pa. By R. A. Little

JUN 24 19[illegible]
BUREAU V. S.

MARYLAND 5438 05413

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 24 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 2117 Homewood Avenue

3. NAME OF DECEASED (Type or Print) (First) Henry (Middle) F. (Last) Deckert
4. DATE OF DEATH (Month) June (Day) 19 (Year) 1954
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH 9-8-1869
9. AGE last birthday 84 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) paper cutter
10b. KIND OF BUSINESS OR INDUSTRY Unk.
11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Daniel Deckert
14. MOTHER'S MAIDEN NAME Florence L. Sieck
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. (If year, give war or dates of service)
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT AND ADDRESS Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

441X

Immediate cause (a) Bronchopneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 6-15-1954 to 6-19-1954

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with Cerebral Arteriosclerosis — 24 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1, 1954, to 6-19, 1954, that I last saw the deceased alive on 6-19, 1954, and that death occurred at 9:25 P.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) M.D. ADDRESS Sykesville, Md. Springfield State Hosp. DATE SIGNED June 19, 1954

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 6/22/54 NAME OF CEMETERY OR CREMATORY Loudon Park LOCATION (City, town, or county) Balto. (State) Md.

DATE REC'D BY LOCAL REG. June 20, 1954 REGISTRAR'S SIGNATURE C. Harry Weir

24. FUNERAL DIRECTOR Stewart Mowen Co. ADDRESS 108 W. North Av. Balto-1-Md.

MARGIN RESERVED FOR BINDING

M

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RECEIVED
JUN 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5429

CERTIFICATE OF DEATH

Reg. Dist. No. 05414

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Westminster
LENGTH OF STAY (in this place) 15 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 220 ½ E. Main

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 220½ E. Main

3. NAME OF DECEASED: (Type or Print) (First) IRA (Middle) E. (Last) DORSEY SR.

4. DATE OF DEATH: (Month) JUNE (Day) 5 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: NOV. 11-1860

9. AGE last birthday: 93 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. farmer, tenant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frd. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U-S-A-

13. FATHER'S NAME: James D. Dorsey

14. MOTHER'S MAIDEN NAME: Elizabeth Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Ira E. Dorsey 220 E. Main Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) acute Cardiac Decompensation	4 hrs
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Chronic Myocarditis	5 yrs
DUE TO		
	(c) Chronic Interstitial Nephritis	7 yrs

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Chronic Bronchitis — 42 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. -, 1912, to June 5, 1954, that I last saw the deceased alive on June 4, 1954, and that death occurred at 8 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Lelia R. Foutz M.D. ADDRESS Westminster Md. DATE SIGNED 6-6-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF June 7 1954

NAME OF CEMETERY OR CREMATORY St. John Cemetery

LOCATION (City, town, or county) Ellicott City (State) Md.

DATE REC'D BY LOCAL REG. Jun 6-54

REGISTRAR'S SIGNATURE Harriet S. Miller

24. FUNERAL DIRECTOR H. Bankard & Son ADDRESS Westminster, Md.

RECEIVED
JUN 8
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05415

5439 **CERTIFICATE OF DEATH** Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Finebro
LENGTH OF STAY (in this place) 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Finebro
STREET ADDRESS (If rural give location) Finebro RD

3. NAME OF DECEASED: (Type or Print) (First) IRENIA (Middle) BAUGHMAN (Last) DUBS
4. DATE OF DEATH: (Month) June (Day) 10 (Year) 1954
5. SEX: F.
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Dec 6-1891
9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME: Amphrey Baughman
14. MOTHER'S MAIDEN NAME: Laura Roser
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Robert Dubs Finebro, Md RD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171X

Immediate cause (a) Carcinoma Cervix — Interval Between Onset And Death: 1 yr

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Diabetes — 2 yrs

DUE TO

(c) Arteriosclerosis — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1948, to June 10, 1954, that I last saw the deceased alive on June 8, 1954, and that death occurred at 4 AM, from the causes and on the date stated above.

SIGNATURE W H Foard (Degree or title) M.D. ADDRESS Manchester, Md DATE SIGNED 6/10/54

23. BURIAL, CREMATION, REMOVAL (Specify) Buried
DATE THEREOF 6/13/54
NAME OF CEMETERY OR CREMATORY Black Rock Church
LOCATION (City, town, or county) (State) Finebro, Md RD

DATE REC'D BY LOCAL REGISTRAR June 12-54
REGISTRAR'S SIGNATURE Mrs. W P L Donner
24. FUNERAL DIRECTOR H Seiple & Son H Seiple
ADDRESS Glen Rock Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 1(
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05416

5440 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland — LENGTH OF STAY (in this place): 4yrs. 1mo.	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hosp.	STREET ADDRESS (If rural give location): 2604 E. Jefferson St.

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Catherine (Last) Frey

4. DATE OF DEATH: (Month) 6 (Day) 20 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 6-25-1873

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert O. Elliot

14. MOTHER'S MAIDEN NAME: Kate Philpot

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service) ----

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 470X (a) Lobar Pneumonia — Interval Between Onset And Death: 1 wk.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis — 4 yrs

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis, simple deterioration

19a. DATE OF OPERATION: ----

19b. MAJOR FINDINGS OF OPERATION: -----

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ----

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----

(CITY OR TOWN) ----- (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ----- m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? --------

22. I hereby certify that I attended the deceased from 7-10-, 1950, to 6-20-, 1954, that I last saw the deceased alive on 6-20-, 1954, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

SIGNATURE M H Martin M D (Degree or title) ADDRESS Sykesville Md DATE SIGNED 6-20-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 6-26-54 — NAME OF CEMETERY OR CREMATORY New Cathedral — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR June 25, 1954 — REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR Weer & Haight — ADDRESS Sykesville, Md.

Luther H. Haight

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

REC
JUN 28 1954
BUREAU U. S.

Film#G167 Item# 2 6/14/54emf

5441 MARYLAND STATE DEPARTMENT OF HEALTH 05417

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Virginia COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville 2 — LENGTH OF STAY (in this place): [illegible]	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fallschurch
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Grand View Mansion, Sykesville 2 Md	STREET ADDRESS (If rural, give location): ---

3. NAME OF DECEASED (Type or Print) (First) Horace (Middle) M (Last) Gaston			4. DATE OF DEATH (Month) June (Day) 16 (Year) 1954		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: Oct 24-1860	9. AGE last birthday: 93 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor (rtd)	10b. KIND OF BUSINESS OR INDUSTRY: Building		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Horace M. Gaston			14. MOTHER'S MAIDEN NAME: ? Stevens		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.: 227-30-7884A	17. INFORMANT AND ADDRESS: Mr. J. H. Gaston-120 E. 25th St.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) hypertensive cardio vascular disease	? years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis	? years
	(c) myocarditis — senility	? years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 27 April, 1954, to 10 June, 1954, that I last saw the deceased alive on 10 June 1954, and that death occurred at 8:20 A m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) M. D. ADDRESS: Sykesville P.O., Md. DATE SIGNED: 10 June 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 6/12/54	NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.	LOCATION (City, town, or county) (State): Balto., Md.
DATE REC'D BY LOCAL REG.: 6-1-54	REGISTRAR'S SIGNATURE: [signature]	24. FUNERAL DIRECTOR: Wm. J. Pickner & Sons	ADDRESS: Balto. 17, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

5442

05418

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15A-5-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Sykesville
LENGTH OF STAY (in this place) 24 y
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield St. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Prince George
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westwood
STREET ADDRESS — (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) AGNES (Last) GOLDSMITH
4. DATE OF DEATH (Month) June (Day) 13 (Year) 19 54
5. SEX: Fem
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 12 - 1903
9. AGE Last birthday: 51 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE W. NOTHEY
14. MOTHER'S MAIDEN NAME: FANNIE CALLAHAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: York —
17. INFORMANT & ADDRESS: Spx. Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Pulmonary edema & myocardial infarct	12 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	Chr. Valvular heart disease	24 years
	DUE TO (c)	Schizophrenia - Katatonic	28 years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: 20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Monk M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 6/13/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 6/16/54
NAME OF CEMETERY OR CREMATORY Emmanuel Methodist
LOCATION (City, town, or county) (State) Forestead Md.

DATE REC'D BY LOCAL REG. June 14, 1954
REGISTRAR'S SIGNATURE C. Henry Tolson
24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, MD.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - ■ - 53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Uniontown; LENGTH OF STAY (In this place) life; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll; CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Uniontown; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) LeRoy (Middle) (Last) Haines

4. DATE OF DEATH (Month) (Day) (Year): June 11, 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: January 7, 1892

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Crusher operator, Cement Plant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathar Haines

14. MOTHER'S MAIDEN NAME: Fannie Stultz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 213-03-1046

17. INFORMANT & ADDRESS: Mrs. Alverta S. Haines, Uniontown, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: 5 mi

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James I. Moore M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 6/11/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF 6/14/54 | NAME OF CEMETERY OR CREMATORY Lutheran Cemetery | LOCATION (City, town, or county) (State) Uniontown, Maryland

DATE REC'D BY LOCAL REG. June 12, 1954 | REGISTRAR'S SIGNATURE Margaret R. Engle

24. FUNERAL DIRECTOR ADDRESS C. O. Fuss & Son, Taneytown, Maryland

RECEIVED
JUN 15
U. S.

MARYLAND 5444

05420

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH — COUNTY: CARROLL — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: FLORIDA — COUNTY: MARTIN
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: SYKESVILLE — LENGTH OF STAY (in this place): 4 MONTHS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: STUART —
HOSPITAL OR INSTITUTION OR STREET ADDRESS: OAKLAND ROAD	STREET ADDRESS (If rural, give location): 67 W. 2nd St.

3. NAME OF DECEASED (Type or Print)	(First) HARRY	(Middle) EDGAR	(Last) HEFFNER	4. DATE OF DEATH	(Month) JUNE (Day) 24 (Year) 1954
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: FEB 15-1877	9. AGE last birthday: 77 yrs.	If under 1 year: Months — Days — If under 24 hrs: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LAUNDRY BUSINESS	10b. KIND OF BUSINESS OR INDUSTRY: LAUNDRY	11. BIRTHPLACE (State or foreign country): READING — PA.	12. CITIZEN OF WHAT COUNTRY: USA		
13. FATHER'S NAME: FRANK M. HEFFNER	14. MOTHER'S MAIDEN NAME: EMMA HEMIG				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 170-05-5889	17. INFORMANT AND ADDRESS: MRS HARRY E. HEFFNER —			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) [illegible] - [illegible]IGHT	7 [illegible]
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) [illegible]	[illegible]
	(c) [illegible]	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. [illegible] SUFFIE[illegible] — YEA[illegible]

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from [illegible], 19[illegible], to [illegible] 24, 19[illegible], that I last saw the deceased alive on [illegible] 19[illegible], and that death occurred at 11:20 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED [illegible]

23. BURIAL, CREMATION REMOVAL (Specify) [illegible]	DATE [illegible]	NAME OF CEMETERY OR CREMATORY [illegible]	LOCATION (City, town, or county) (State) [illegible]
DATE REC'D BY LOCAL REG. [illegible] 25, 1954	REGISTRAR'S SIGNATURE [illegible]	24. FUNERAL DIRECTOR [illegible]	ADDRESS [illegible] Pa.

MARGIN RESERVED FOR BINDING

05421

MARYLAND 5445 **STATE DEPARTMETT OF HEALTH**

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) 5yr.11mo.25d.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 021
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural, give location) 3621 Oak Avenue

3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle)	(Last) Karpus	4. DATE OF DEATH	(Month) June (Day) 20 (Year) 1954
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 10-5-91	9. AGE last birthday 62 yrs.	If under 1 year Months Days; If under 24 hrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Unk.
13. FATHER'S NAME John Baltrusaitis			14. MOTHER'S MAIDEN NAME Mary Zubritskas		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service)	16. SOCIAL SECURITY No. Unk.	17. INFORMANT AND ADDRESS Springfield State Hospital		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4 d.v.l Immediate cause	(a) Coronary Infarct	8 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized and coronary arteriosclerosis	7 years
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with cerebral arteriosclerosis	7 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-4, 1950, to June 20, 1954, that I last saw the deceased alive on June 20, 1954, and that death occurred at 10:10 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Walther J Sonnenfeldt	M.D.	Springfield State Hospital	June 21, 1954

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-25-54	Lithuanian National	Chicago, Ill.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
June 21, 1954	C. Harry Weber	Wm Cook, Inc.	1217 [illegible] St. [illegible]

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 23
U.S.

05422

MARYLAND

STATE DEPARTMETT OF HEALTH

5446

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll County MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md. LENGTH OF STAY (in this place) 14 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location) Sykesville

3. NAME OF DECEASED (Type or Print)	(First) HARRY	(Middle) DENTON	(Last) Keefer	4. DATE OF DEATH (Month) June (Day) 6 (Year) 1954
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5 Nov. 1875	9. AGE last birthday 78 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Carpenter	11. BIRTHPLACE (State or foreign country) Md - Carroll County	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Keefer		14. MOTHER'S MAIDEN NAME Annie Bart		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. Unk-	17. INFORMANT AND ADDRESS Mrs Ella Keefer		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Arrest

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH: 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) None	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	(CITY OR TOWN) — (COUNTY) — (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) None m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 3 June, 1954, to 6 June, 1954, that I last saw the deceased alive on 6 June, 1954, and that death occurred at 2 A.m., from the causes and on the date stated above.

SIGNATURE Howard E Hall MD (Degree or title) ADDRESS Sykesville, Md. DATE SIGNED 6 June 54

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 6-8-54	NAME OF CEMETERY OR CREMATORY Baile's	LOCATION (City, town, or county) Dennings Carroll (State) Md
DATE REC'D BY LOCAL REG. June 7, 1954	REGISTRAR'S SIGNATURE C. Harry Weer	24. FUNERAL DIRECTOR Weer & Haight - Sykesville, Md ADDRESS Luther H. Haight	

MARGIN RESERVED FOR BINDING

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JUN 1[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05423

5447 **CERTIFICATE OF DEATH**

Reg. Dist. No. 76

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg Rural
LENGTH OF STAY (in this place) 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg - Rural
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) MARSHALL - F - KNIGHT

4. DATE OF DEATH: (Month) (Day) (Year) June 19 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Dec 24-1880
9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Knight
14. MOTHER'S MAIDEN NAME: Frances Gamber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO.: —
17. INFORMANT & ADDRESS: Mrs Russell Dell - Westminster Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 3 days

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertension — 5 yrs

DUE TO

(c) Arteriosclerosis — years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Injured intervertebral disc 5 years

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1-1-28 to 6-19, 1954, that I last saw the deceased alive on 6-19-54, and that death occurred at 10:15 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) James G. Gaffell M.D. ADDRESS Reisterstown Md DATE SIGNED 6-19-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF June 22 1954
NAME OF CEMETERY OR CREMATORY Patapsco
LOCATION (City, town, or county) (State) Carroll Co Md

DATE REC'D BY LOCAL REGISTRAR 6/29/54
REGISTRAR'S SIGNATURE Harriett Miller
24. FUNERAL DIRECTOR Edw C Tipton, ADDRESS Hampstead Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 29 19[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05424

5448 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 8yrs. 11months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) Unk — ✓

3. NAME OF DECEASED: (Type or Print) (First) Della (Middle) (Last) Lewis
4. DATE OF DEATH: (Month) June (Day) 13 (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 10-26-1870
9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unk — Gott
14. MOTHER'S MAIDEN NAME: Unk —
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: Unk —
17. INFORMANT & ADDRESS: Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Pulmonary Embolism — 48 hours
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease — Many years
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis — Many years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 11, 1954, to June 13, 1954, that I last saw the deceased alive on June 13, 1954, and that death occurred at 5:45 p.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) Ray H. Hayes M.D. ADDRESS Springfield State Hosp. DATE SIGNED June 14, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 6-17-54 NAME OF CEMETERY OR ~~CREMATORY~~ Mount Carmel LOCATION (City, town, or county) (State) Balto. Md.
DATE REC'D BY LOCAL REGISTRAR June 15, 1954 REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Wm Cook, Inc. ADDRESS 1217 St Paul St. Balto.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

RECEIVED
JUN 17 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05425

5449 **CERTIFICATE OF DEATH** Reg. Dist. No. 81

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
LENGTH OF STAY (in this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
STREET ADDRESS (If rural give location) Main St.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) CHARLES EDWARD LIPPY

4. DATE OF DEATH: (Month) (Day) (Year) June 20 1954

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 10/4/1880
9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life even if retired: former retired
10b. KIND OF BUSINESS OR INDUSTRY: owner
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Michael Lippy
14. MOTHER'S MAIDEN NAME: Ellen Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: 212-24-5217
17. INFORMANT & ADDRESS: Rachel Lippy, Union Bridge, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis
DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954 to June, 1954, that I last saw the deceased alive on June 20, 1954 and that death occurred at 7 A.M. from the causes and on the date stated above.
SIGNATURE J. H. Mosby (Degree or title) M.D. ADDRESS Union Bridge DATE SIGNED June 20

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 6/23/54
NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.
LOCATION (City, town, or county) (State) Woodsboro, Md

DATE REC'D BY LOCAL REGISTRAR June 21, 1954
REGISTRAR'S SIGNATURE Leslie L. Kipp
24. FUNERAL DIRECTOR D. D. Hartzler & Sons ADDRESS Union Bridge, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 22
BUREAU V. S.

5450 MARYLAND STATE DEPARTMENT OF HEALTH 05426

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6-375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; LENGTH OF STAY (In this place) 4 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Longview Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taylorsville; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Salome; (Middle) Elizabeth; (Last) Lovell

4. DATE OF DEATH: (Month) June; (Day) 24; (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Aug 14, 1873

9. AGE last birthday: 80 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathan Hanson Franklin

14. MOTHER'S MAIDEN NAME: Martha Ellen Grimes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Self + Nursing Home Record.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypertension, Cardiac Renal Vascular Disease — Interval Between Onset and Death: ?

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senile Myocarditis. —

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gangrene Rt foot. — 4 wks

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

(CITY OR TOWN): —

(COUNTY): —

(STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 6, 1950, to June 24, 1954, that I last saw the deceased alive ~~since~~ June 24, 1954, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE: Lloyd E. Bull (Degree or title) M.D. ADDRESS Hampstead Md DATE SIGNED 6/24/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 6-26-1954

NAME OF CEMETERY OR CREMATORY: Taylorsville

LOCATION (City, town, or county): Carroll Co. (State): Md.

DATE REC'D BY LOCAL REG. 6-25-54

REGISTRAR'S SIGNATURE: ~~Estelle M. Hyatt~~ Mrs. M. P. S. Denner

24. FUNERAL DIRECTOR: C. M. Waltz ADDRESS Winfield. Md.

JUN 29 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05427

5451 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carrol MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 13 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield St. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 3143 Tilden Drive ✓

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) — (Last) Markey
4. DATE OF DEATH: (Month) 6 (Day) 19 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED,~~ (Specify): Unknown
8. DATE OF BIRTH: 5-10-1910
9. AGE last birthday: 44 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): CLERK
10b. KIND OF BUSINESS OR INDUSTRY: Mfg Bldg. Materials Windows, Doors +
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Markey
14. MOTHER'S MAIDEN NAME: Minnie M Jordan

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES ✓ (If Yes, give war or dates of service) 2 WW
16. SOCIAL SECURITY No.: 217-09-4953
17. INFORMANT & ADDRESS: Mrs. Ola Bigham 3143 Tilden Drive, Baltimore, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

802X

Immediate cause (a) Myocardial disease — several wks

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Nutritinal defficiency — several mos

DUE TO

(c) CBS due to brain trauma, psychotic — several mos.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) struck by train
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 6 1953 m.
INJURY OCCURED While at Work ☐ Not While At Work ☒
HOW DID INJURY OCCUR? Unknown

22. I hereby certify that I attended the deceased from 3/9/1954, to 6/19/1954, that I last saw the deceased alive on 6/19/1954, and that death occurred at 6:10 pm from the causes and on the date stated above.
SIGNATURE A. Lubizka (Degree or title) M.D. ADDRESS Springfield Hospital DATE SIGNED 6/19/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 6-22-54
NAME OF CEMETERY OR CREMATORY Balto National Cemetery
LOCATION (City, town, or county) Baltimore Md. (State)
DATE REC'D BY LOCAL REGISTRAR [illegible]
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR Frank H. Bertz 814 W 36th St. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05428

5452 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Howard
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville — LENGTH OF STAY (in this place) 7 months	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location) 55 College Avenue ✓

3. NAME OF DECEASED: (Type or Print) (First) Marion (Middle) Lee (Last) Meade

4. DATE OF DEATH: (Month) June (Day) 13 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 12, 1891

9. AGE last birthday: 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Office work

10b. KIND OF BUSINESS OR INDUSTRY: Unk -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles H. Meade

14. MOTHER'S MAIDEN NAME: Gertrude Echenrode

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: Unk -

17. INFORMANT & ADDRESS: Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Coronary occlusion	26 days
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Arteriosclerotic cardio-vascular disease	Many years
	DUE TO (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis with psychotic reaction

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-9, 1953, to 6-13, 1954, that I last saw the deceased alive on 6-13, 1954, and that death occurred at 11:55 p.m., from the causes and on the date stated above.

SIGNATURE Dr. Ira Kamm (Degree or title) M.D. — ADDRESS 4 Grand View Ave., Sykesville — DATE SIGNED June 14, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 6/16/54 — NAME OF CEMETERY OR CREMATORY St. John's Cemetery — LOCATION (City, town, or county) Ellicott City, (State) Md.

DATE REC'D BY LOCAL REGISTRAR June 14, 1954 — REGISTRAR'S SIGNATURE C. Harry Weir

24. FUNERAL DIRECTOR Easton Sons, Catonsville — ADDRESS 28, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 17 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05429

5453 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS HENRYTON STATE HOSPITAL O.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Queen Anne
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt.3, Box 162, Centerville
STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) WEBSTER (Last) MORRIS JR.

4. DATE OF DEATH: (Month) June (Day) 18 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Nov.15,1908
9. AGE last birthday: 45 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farm helper
11. BIRTHPLACE (State or foreign country): Starr, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Webster Morris, Sr.
14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Sarah Elizabeth Burgess

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No: 214-32-0978 ~~Unknown~~
17. INFORMANT & ADDRESS: Mary Morris (wife) Centerville, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X

Immediate cause (a) Far adv. bilat. cavitary tbc.

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death: 19 1 yr.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 16, 1954, to June 18, 1954, that I last saw the deceased alive on June 18, 1954, and that death occurred at 8:30 A.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) T.F. Vestal M.D. ADDRESS Henryton, Maryland DATE SIGNED 6/18/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF June 21, 1954
NAME OF CEMETERY OR CREMATORY Brownsville Cemetery
LOCATION (City, town, or county) (State) N. Centerville, Maryland
DATE REC'D BY LOCAL REGISTRAR 6-18-54
REGISTRAR'S SIGNATURE Albert R. Swankhans
Deputy Local
24. FUNERAL DIRECTOR Barton Bros. ADDRESS Centerville, Maryland

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

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RECEIVED
JUN
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5430

CERTIFICATE OF DEATH

Reg. Dist. No. 05431

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Westminster
LENGTH OF STAY (in this place) 86
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) Washington Rd.

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) E. D. W. (Last) OURSLER

4. DATE OF DEATH: (Month) June (Day) 2 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	Widower	Sept. 3, 1867	86 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retd. Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Ourslar
14. MOTHER'S MAIDEN NAME: Chloe Brothers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Miss Helen Ourslar Westminster R.1. Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cardio-renal-vascular disease — DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) senility — DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: (a) 3 years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
None	—	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No	—	—		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
—			M.		—

22. I hereby certify that I attended the deceased from June 1, 1951, to June 2, 1954, that I last saw the deceased alive on June 2, 1954, and that death occurred at 9:30 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) J. H. Billingslea, M.D. ADDRESS Westminster, Md. DATE SIGNED 6-2-54

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	June 4, 1954	Westminster Cemetery	Westminster	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6-3-54	Harriet H. Miller	J. H. Bankard & Son	Westminster, Md.

RECEIVED
JUN 7 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05432

5454 CERTIFICATE OF DEATH Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Manchester. | LENGTH OF STAY (in this place) 2 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 219 York St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester.
STREET ADDRESS (If rural give location) 219 York St.

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Linwood (Last) Parks Sr.

4. DATE OF DEATH: (Month) June (Day) 6, (Year) 1954

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH: January 4 1887 | 9. AGE last birthday: 67 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY: Own Farm. | 11. BIRTHPLACE (State or foreign country): Cockeysville, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Linwood Parks. | 14. MOTHER'S MAIDEN NAME: Jennie Lee.

15 WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT'S ADDRESS: John L. Parks, 219 York St. Manchester, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Colon with — Interval Between Onset And Death: 3 yrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) metatasis to Lungs -

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 9, 1954, to June 6, 1954, that I last saw the deceased alive on June 5, 1954, and that death occurred at 4.25 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) W. H. Foard M.D. | ADDRESS Manchester, Md | DATE SIGNED 6/6/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF June 9 1954 | NAME OF CEMETERY OR CREMATORY Middletown Cemetery | LOCATION (City, town, or county) (State) Freeland, Balto. Co. Md.

DATE REC'D BY LOCAL REGISTRAR June 6-54 | REGISTRAR'S SIGNATURE Mrs. H.R.S. Donnell | 24. FUNERAL DIRECTOR Jacob Hartenstein, | ADDRESS New Freedom, Pa.

VS. A15

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JUN 1[illegible]
BUREAU V. S.

5455 05433 wc

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
LENGTH OF STAY (In this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS St Louis

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural Annapolis
STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED: (Type or Print) (First) FRANCIS (Middle) WILLARD (Last) PARLETT

4. DATE OF DEATH (Month) June (Day) 10 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: November 16, 1893
9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert B. Pumphrey
14. MOTHER'S MAIDEN NAME: Mary McCoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.: NO
17. INFORMANT & ADDRESS: Mrs. Hallett Baile, New Windsor Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

1141

Immediate cause (a) Carcinoma uterus — INTERVAL BETWEEN ONSET AND DEATH: Months

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.,
21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T Marsh ~~Deputy Medical~~ M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED June 10, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 6-12-54
NAME OF CEMETERY OR CREMATORY [illegible]
LOCATION (City, town, or county) (State) [illegible]

DATE REC'D BY LOCAL REG. 6-10-54
REGISTRAR'S SIGNATURE L
24. FUNERAL DIRECTOR Stewart & Mowlen Co. ADDRESS 108 W. North Ave. Baltimore

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5456

CERTIFICATE OF DEATH

WC 05434

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville X

LENGTH OF STAY (in this place) 16yrs, 8m. 25d.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City

STREET ADDRESS (If rural give location) 123 S. Monroe Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month) (Day) (Year)
Annie		Rausch	June 8 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	3-11-79	75 yrs.		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housework	Home	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Henry Miller	Annie Unk-

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	—	Unk-	Springfield State Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Pulmonary Embolism	36 hr.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Congestive Heart Failure	36 hr.
	DUE TO (c) ~~Arteriosclerotic cardio-vascular disease~~	many years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, paranoid type.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 7, 19 54, to June 8, 19 54, that I last saw the deceased alive on June 8, 19 54, and that death occurred at 4:20 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Ray Hayes M.D.	Springfield State Hospital	June 8, 1954

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-11-54	Springfield Hospital	Sykesville, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
June 11, 1954	C. Harry Eckel	Wm. J. Haight - Luther N. Haight	Sykesville, Md

VS. A15

RECEIVED
JUN 17 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05435

5457 **CERTIFICATE OF DEATH** Reg. Dist. No. 71

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester. LENGTH OF STAY (in this place) 2½ yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Longview Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Penna. COUNTY Adams
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gettysburg
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) Sarah (Middle) R (Last) Rider
4. DATE OF DEATH: (Month) June (Day) 10 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH: Nov. 17, 1859
9. AGE last birthday: 94 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home.
11. BIRTHPLACE (State or foreign country): Gettysburg, Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levi Plank
14. MOTHER'S MAIDEN NAME: Mary Weikert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: —
17. INFORMANT & ADDRESS: Mrs Maryland Eppler. RD 3 Hanover Penna.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis ?
DUE TO
Antecedent cause(s) (b) Arteriosclerotic Cardiovascular Disease
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) M. —
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept 4, 1951, to June 10, 1954, that I last saw the deceased alive on June 9, 1954 and that death occurred at 12:30 p.m., from the causes and on the date stated above.
SIGNATURE Joseph E Bush (DEGREE OR TITLE) MD ADDRESS Hampshire Md DATE SIGNED June 10 '54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF June 12-54 NAME OF CEMETERY OR CREMATORY St. Francis LOCATION (City, town, or county) Gettysburg (State) Pa
DATE RECD BY LOCAL REG. June 11-54 REGISTRAR'S SIGNATURE Mrs. W. P. Denner
24. FUNERAL DIRECTOR J. Milton Bender ADDRESS Gettysburg Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

RECEIVED
JUN 16 19
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05436

5458

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead
LENGTH OF STAY (in this place) 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) AMANDA - WILLELLA - RINAMAN

4. DATE OF DEATH: (Month) (Day) (Year) June 4 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: Nov 15 - 1879

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Huk

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Brilhart

14. MOTHER'S MAIDEN NAME: Mandilla Hoover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: ✓

17. INFORMANT & ADDRESS: Mrs Donald Lace, Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Pulmonary Asthma

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Hypertensive Cardio renal Vascular disease

DUE TO (c)

Interval Between Onset And Death: 15 min (?)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June 4, 1948; to June 4, 1954, that I last saw the deceased alive on June 4, 1954, and that death occurred at 2:55 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) Joseph E. Bush MD

ADDRESS Hampstead Md

DATE SIGNED 6/4/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF June 7/54

NAME OF CEMETERY OR CREMATORY Hampstead

LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REGISTRAR June 6-1954

REGISTRAR'S SIGNATURE Henry J Lens

24. FUNERAL DIRECTOR Edw C Tipton

ADDRESS Hampstead Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 11 1954
BUREAU V. S.

05437

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5459 **CERTIFICATE OF DEATH** Reg. Dist. No. 70

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
LENGTH OF STAY (in this place) 40 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Irene (Middle) Reifsnider (Last) Sauble

4. DATE OF DEATH: (Month) June (Day) 11, (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Nov. 4, 1876

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William J. Reifsnider

14. MOTHER'S MAIDEN NAME: Emma Merrit

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mr. Norman R. Sauble, Taneytown, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Ventricular fibrillation	2 minutes
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) myocardial degeneration & coronary insufficiency	2 years
DUE TO		
	(c) Arterio-sclerotic heart disease	5 years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 19 51, to 11 June, 19 54, that I last saw the deceased alive on 9 June, 19 54, and that death occurred at 6:02 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Walter E. Stevens, M.D. ADDRESS E.O.T. DATE SIGNED 11 June 1954.

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF June 13, 1954 | NAME OF CEMETERY OR CREMATORY Lutheran Cemetery | LOCATION (City, town, or county) Taneytown, Maryland (State)

DATE REC'D BY LOCAL REG. June 11, 1954 | REGISTRAR'S SIGNATURE Ethel M. Mehring Local

24. FUNERAL DIRECTOR C.O.Fuss & Son, Taneytown, Maryland ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15 8-51

RECEIVED
JUN 14 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05438

5460 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.
LENGTH OF STAY (in this place) 2yrs. 3mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge
STREET ADDRESS (If rural give location) ----

3. NAME OF DECEASED: (Type or Print) (First) Emma (Middle) Lee (Last) Shriver
4. DATE OF DEATH: (Month) 6-28- (Day) (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 12-3-1877
9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nursing
10b. KIND OF BUSINESS OR INDUSTRY: Unk.
11. BIRTHPLACE (State or foreign country): Frederick Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Daniel Shriver
14. MOTHER'S MAIDEN NAME: Sara Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service) ----
16. SOCIAL SECURITY No.: Unk.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Lobar Pneumonia	10 days
DUE TO		
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) Chronic myocarditis - Hypertension	10 years
DUE TO		
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis, simple deterioration — 4 yrs.
19a. DATE OF OPERATION: ----
19b. MAJOR FINDINGS OF OPERATION ----
20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) ----
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----
(CITY OR TOWN) (COUNTY) (STATE) ----
TIME OF INJURY (Month) (Day) (Year) (Hour) ----- m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 4-20-, 1952, to 6-27-, 1954, that I last saw the deceased alive on 6-27-, 1954, and that death occurred at 6:05A.M., from the causes and on the date stated above.
SIGNATURE M. N. Mastin, M.D. (Degree or title) ADDRESS Springfield State Hosp., Sykesville, Md. DATE SIGNED 6-28-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 7-1-54
NAME OF CEMETERY OR CREMATORY Pipe Creek
LOCATION (City, town, or county) (State) New Windsor, Md.
DATE REC'D BY LOCAL REGISTRAR June 29, 1954
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR D. D. Hartzler & Sons - New Windsor, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 2 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05439

5461 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 4mos.23days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 286 Mason Court

3. NAME OF DECEASED: (Type or Print) (First) Ada (Middle) Edith (Last) Smith
4. DATE OF DEATH: (Month) June 8 (Day) (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 2-10-87
9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harris Mitnick
14. MOTHER'S MAIDEN NAME: Sarah Schiller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of [redacted])
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 3 days

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease — several years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction. approx. 1yr.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 5, 1954, to June 8, 1954, that I last saw the deceased alive on June 8, 1954, and that death occurred at 12:20p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Ray H. Hayes M.D. Medical Officer
ADDRESS Springfield State Hosp.
DATE SIGNED June 8, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF June 9/54
NAME OF CEMETERY OR CREMATORY Hebrew Friendship
LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REGISTRAR 6-9-54
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Sol. Levinson & Bros.
ADDRESS 1124-26 W. North Avenue

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05440

5462 **CERTIFICATE OF DEATH**

Reg. Dist. No. 7-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Manchester

LENGTH OF STAY (in this place) 14 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Longview Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Balto.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson

STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Maude		Staley	June	12	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widow	Nov 14. 1869	84 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
House wife	Home	Pennsylvania	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Ruel Skinner	Emma Chapman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	—	Self - Nursing Home Record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage.	7 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Hypertensive Cardio Vascular Renal	?
	DUE TO (c) —	

443

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—

TIME (Month) OF INJURY	(Day)	(Year)	(Hour) M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
—	—	—	—	—	—

22. I hereby certify that I attended the deceased from Aug 10, 1953 to June 12, 1954 that I last saw the deceased alive on June 11, 1954, and that death occurred at 7 A.M. m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Joseph E Beck M.D.		Hampstead Md	6/12/54

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 15. 1954	Boonsboro Cemetery	Boonsboro Wash. Co. Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
June 14-1954	Mrs. W.P.S. Donnell	Wm. F. Bast and Sons	Boonsboro Md

REC
JUN
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05441

5463 CERTIFICATE OF DEATH Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Carroll MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Finksburg | LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg, Nrusing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore

STREET ADDRESS (If rural, give location) Pikesville Road Zone #8

3. NAME OF DECEASED: (Type or Print) (First) Wiliom (Middle) A.E. (Last) Stapf

4. DATE OF DEATH: (Month) June (Day) 29th (Year) 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed	June 21, 1873	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Ret. Blacksmith		Baltimore, Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Christian Stapf	Margaret Kerns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
	212-01-8352	Miss Vida D. Stapf, Pikesville Rd. Zone 8

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage	1 week
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Hypertension	3 yrs
DUE TO		
	(c) Arteriosclerosis	3 yrs

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 1-1 19 54 to 6-29-54, 19..., that I last saw the deceased alive on 6-29-54, 19..., and that death occurred at 11:25 a.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
James L. Duffy	M.D.	Reisterstown, Md	6-30-54

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 2, 1954	Loudon Park Cemetery	Baltimore, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-3-54	C. W. Hedrick	Leonard J. Ruck	5305 Harford Road #14

Ruck Funeral Home -
5305 Harford Rd
Balto, 4 Md

5464

05442

MARYLAND STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Near Union Mills — LENGTH OF STAY (In this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Near Union Mills
HOSPITAL OR INSTITUTION OR STREET ADDRESS Myers District Westminster, Md. R. D. 3	STREET ADDRESS (If rural, give location) Myers District, Westminster, Md. R-3

3. NAME OF DECEASED (Type or Print) (First) Amanda (Middle) Elizabeth (Last) Swenk				4. DATE OF DEATH (Month) 6/12/54 (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 12/29/1875	9. AGE last birthday 78 yrs.	If under 1 year Months, Days; If under 24 hrs. Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (Housework)		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Krumrine			14. MOTHER'S MAIDEN NAME Rebecca Shaffer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Westminster, Md. R-3		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443x

Immediate cause (a) Hypertensive Heart Disease — 10 yrs

Antecedent cause(s) (b) Arteriosclerosis generalized — 10 yrs

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Nephritis Chronic — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950 to June 12, 1954, that I last saw the deceased alive on June 12, 1954, and that death occurred at 11 P m., from the causes and on the date stated above.

SIGNATURE Sergeo S. Thomas (Degree or title) ADDRESS Md. Hanover PA. DATE SIGNED 6/14/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 6/16/54	NAME OF CEMETERY OR CREMATORY Bachmans Valley Cemetery	LOCATION (City, town, or county) (State) Nr. Westminster Carroll Co. Md.
DATE REC'D BY LOCAL REG. 6-14-54	REGISTRAR'S SIGNATURE Harriet H. Miller	24. FUNERAL DIRECTOR J. M. Little & Son Per R. A. Little	ADDRESS Littlestown, Pa.

MARGIN RESERVED FOR BINDING

M

I

RECEIVED
JUN 16 1954
BUREAU V. S.

5465 05443

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 77

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Greenmount
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route #30

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Greenmount
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) SILAS (Middle) EDWARD (Last) TRACEY

4. DATE OF DEATH (Month) June (Day) 29 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower
8. DATE OF BIRTH: Aug 24-1885
9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: House
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cornelius Tracey
14. MOTHER'S MAIDEN NAME: Sarah Bossom

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.: 220-14-2547
17. INFORMANT & ADDRESS: Mrs Leroy Schultz, Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Massive hemothorax, bilateral,
DUE TO traumatic rupture of aorta

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ ~~CAUSE OF~~ DEATH.
21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY road
21c. (City or town) (County) (State) Rt. 30-Greenmount-Carroll Cty., Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY June 29, 1954 9:00 A.M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☒
21f. HOW DID INJURY OCCUR? Driving auto which collided with tractor Partial

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Paul F Guern M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED June 30, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF July 2/54
NAME OF CEMETERY OR CREMATORY Mr Zion
LOCATION (City, town, or county) (State) Balto Co Md

DATE REC'D BY LOCAL REG. 7/1/54
REGISTRAR'S SIGNATURE Henry J Kells
24. FUNERAL DIRECTOR Edw C Tipton, Hampstead Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

MARYLAND 5466 05444

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 39 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville
STREET ADDRESS (If rural, give location) 1220 N. Rolling Road

3. NAME OF DECEASED (Type or Print): (First) Augusta (Middle) Virginia (Last) Trail

4. DATE OF DEATH: (Month) June (Day) 21 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 9-13-1882

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Henry Poole

14. MOTHER'S MAIDEN NAME: Ida Virginia Vernon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary infarction	24 hrs.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary and generalized arteriosclerosis	3 years
	(c) Arrested pulmonary tuberculosis	15 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenic reaction — 39 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15-50, to June 21, 1954, that I last saw the deceased alive on June 21, 1954, and that death occurred at 2:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Walter H. Eisenpfeld M.D. Springfield State Hospital June 22, 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE 6/25/54. — NAME OF CEMETERY OR CREMATORY: Loraine Park Cem. — LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG.: June 22/1954

REGISTRAR'S SIGNATURE: C. Stacy Wood

24. FUNERAL DIRECTOR: Eaton Bros. — ADDRESS: Catonsville 28, Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05445

5467 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINEBORO
LENGTH OF STAY (in this place) 70 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINEBORO
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) PANNEBAKER (Last) WENTZ
4. DATE OF DEATH: (Month) JUNE (Day) 1 (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED
8. DATE OF BIRTH: JAN. 12, 1860
9. AGE last birthday: 94 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): HOUSEKEEPING
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: DAVID PANNEBAKER
14. MOTHER'S MAIDEN NAME: HANNA (UNKNOWN)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT & ADDRESS: Leroy Wentz Lineboro, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

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Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: 4 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio-Sclerotic C-V Disease — Unknown

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-28, 1954, to 6-1, 1954, that I last saw the deceased alive on 6-1, 1954, and that death occurred at 9:05 p.m., from the causes and on the date stated above.

SIGNATURE M. C. Porterfield (Degree or title) M.D. ADDRESS Hampstead Md DATE SIGNED 6-3-54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL. DATE THEREOF JUNE 4, 1954 NAME OF CEMETERY ~~OR CREMATORY~~ LAZARUS LOCATION (City, town, or county) LINEBORO (State) MD.

DATE REC'D BY LOCAL REGISTRAR June 3-54 REGISTRAR'S SIGNATURE Mrs. Wm. Denner

24. FUNERAL DIRECTOR [illegible] ADDRESS Glen Rock, Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 1C
BUREAU V. S.

Fil. #G168 Item# 9
7/2/54 emf

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05446

CERTIFICATE OF DEATH

5468 Reg. Dist. No. 81

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll STATE MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Union Bridge
LENGTH OF STAY (In this place) 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Frederick
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Sabillasville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) HOWARD (Middle) EARL (Last) WILLARD
4. DATE OF DEATH: (Month) June (Day) 27th. (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 3/8/1893
9. AGE last birthday: 61 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life. (Not retired): Telegraph Operator
10b. KIND OF BUSINESS OR INDUSTRY: W.M.R.R.
11. BIRTHPLACE (State or foreign country): Sabillasville
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William Willard
14. MOTHER'S MAIDEN NAME: Emma Moorehead

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No: No
17. INFORMANT & ADDRESS: Mrs Howard E.Willard Union Bridge MD

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: Sudden

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Chronic Myocarditis — years

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/27, 1954, to 6/27., 1954, that I last saw the deceased alive on 6/24, 1954, and that death occurred at ... 4 O.M. from the causes and on the date stated above.
SIGNATURE T. N. Legg (Degree or title) M.D. ADDRESS Union Bridge Md. DATE SIGNED 6/27-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 6/29/1954 NAME OF CEMETERY OR CREMATORY Blue Ridge Cem. LOCATION (City, town, or county) Thurmont Fredk. Co. (State) MD
DATE REC'D BY LOCAL REGISTRAR June 29, 1954 REGISTRAR'S SIGNATURE Leslie [illegible]
24. FUNERAL DIRECTOR M.L.Creager & Son. ADDRESS Thurmont. MD

VS. A15

RECEIVED
JUN 30 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05447

5469 CERTIFICATE OF DEATH

Reg. Dist. No. 54

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lewisville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lewisville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) CLARA (Middle) L. (Last) YAEGER

4. DATE OF DEATH: (Month) June (Day) 2, (Year) 19 54

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 10, 1866

9. AGE last birthday: 87 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Kuhn

14. MOTHER'S MAIDEN NAME: Rosa Wittman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Bertram A. Yaeger, Lewisville, Maryland

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Pulmonary edema	4 hours
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Congestive cardiac failure	one year
	DUE TO (c) Generalized arterio-sclerosis	13 years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-5, 1954, to 6-1, 1954, that I last saw the deceased alive on 6-1, 1954, and that death occurred at 1.15 AM, from the causes and on the date stated above.

SIGNATURE: Bertram R Yaeger — (Degree or title) M.D. — ADDRESS: SYKESVILLE Md. — DATE SIGNED: 6-2-54

23. BURIAL, CREMATION, REMOVAL (Specify): burial — **DATE THEREOF:** 6/4/54 — **NAME OF CEMETERY OR CREMATORY:** Moreland Memorial Park — **LOCATION** (City, town, or county) (State): Parkville, Maryland

DATE REC'D BY LOCAL REGISTRAR: 6/3/54 — **REGISTRAR'S SIGNATURE:** [illegible] — **24. FUNERAL DIRECTOR:** Wm. Cook, Inc., — **ADDRESS:** 1217 St. Paul Street

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05448

5470 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton
LENGTH OF STAY (in this place) 2yrs.8mths.3days
HOSPITAL OR INSTITUTION OR STREET ADDRESS HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Charles
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benedict 08X-2
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) EUGENE (Middle) HARRISON (Last) YOUNG
4. DATE OF DEATH: (Month) June (Day) 18 (Year) 1954
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Sep.
8. DATE OF BIRTH: Oct.13,1895
9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farm helper
11. BIRTHPLACE (State or foreign country): Bryantown, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: [illegible] John Young
14. MOTHER'S MAIDEN NAME: Henrietta Sewell
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: unknown
17. INFORMANT & ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X

Immediate cause (a) Far adv. bilat. cavitary tbc.

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death: 1949 4½ yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-15-, 1951, to 6-18, 1954, that I last saw the deceased alive on 6-18, 1954, and that death occurred at 9:50 a.m., from the causes and on the date stated above.

SIGNATURE T.F. [illegible] (Degree or title) M.D. ADDRESS Henryton, Maryland DATE SIGNED 6-18-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF June 21, 1954
NAME OF CEMETERY OR CREMATORY St. Mary's
LOCATION (City, town, or county) (State) Bryantown, Md.
DATE REC'D BY LOCAL REGISTRAR 6-18-54
REGISTRAR'S SIGNATURE Albert R. [illegible]
Deputy Local
24. FUNERAL DIRECTOR Hunt & Ryon, Waldorf, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 28 1954
BUREAU V. S.

MARYLAND 5471

05450

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (In this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 18,
STREET ADDRESS (If rural, give location): 26 York Court

3. NAME OF DECEASED (Type or Print): (First) William (Middle) David (Last) Zile

4. DATE OF DEATH: (Month) June (Day) 29 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 10-5-72

9. AGE last birthday: 81 yrs. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chicken Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Yard

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Zile

14. MOTHER'S MAIDEN NAME: Mary Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hypostatic pneumonia	4 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial infarction	several months
	(c) Coronary and generalized Arteriosclerosis	unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Chronic brain syndrome due to generalized arteriosclerosis with psychosis — 5 yrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 25, 1954, to June 29, 1954, that I last saw the deceased alive on June 29, 1954, and that death occurred at 8:55 p.m., from the causes and on the date stated above.

SIGNATURE: Walter H. Sonnenfeldt (Degree or title) M.D. ADDRESS: Springfield State Hospital DATE SIGNED: June 30, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE: 7-3-1954
NAME OF CEMETERY OR CREMATORY: Ebenezer
LOCATION (City, town, or county) (State): Carroll Co., Md.

DATE REC'D BY LOCAL REG.: July 2, 1954
REGISTRAR'S SIGNATURE: C. Harvey Wood

24. FUNERAL DIRECTOR: C. M. Waltz, ADDRESS: Winfield, Md.

RECEIVED
JUL 7 1954
BUREAU V. S.